

MINUTES OF MEETING
OF THE INDUSTRIAL COMMISSION OF ARIZONA
Held at 800 West Washington Street
Auditorium and Conference Room 308
Phoenix, Arizona 85007
Thursday, August 23, 2018 – 1:00 p.m.

Present:	Dale L. Schultz	Chairman
	Joseph M. Hennelly, Jr.	Vice Chairman
	Scott P. LeMarr	Commissioner (Telephonic)
	Steven J. Krenzel	Commissioner
	James Ashley	Director
	Jason M. Porter	Deputy Director / General Counsel
	Gaetano Testini	Chief Legal Counsel
	Jacqueline Kurth	Medical Resource Office Manager
	Trevor Laky	Legislative Affairs Chief / Public Information Officer
	Renee Pastor	Self Insurance
	Jessie Atencio	ADOSH Director
	Stacey Rogan	Assistant Chief Legal Counsel
	Kara Dimas	Commission Secretary

Chairman Schultz convened the Commission meeting at 1:00 p.m.

Public Hearing regarding Commission consideration of whether to adopt additional reimbursement guidelines in the Arizona Physicians' and Pharmaceutical Fee Schedule for medications dispensed in settings that are not accessible to the general public (pursuant to Laws 2018, Chapter 101, Section 3).

Chairman Schultz explained the purpose of the public hearing regarding Commission consideration of whether to adopt additional reimbursement guidelines in the Arizona Physicians' and Pharmaceutical Fee Schedule for medications dispensed in settings that are not accessible to the general public.

Coy Jones and Vichayapan Kazimer (PCG Health) discussed PCG Health's white paper regarding the topic of physician dispensing.

Gale Vogler (CopperPoint); Jill Falb (Corvel Corporation); Emily Rice (Arizona Self-Insurers Association); Todd Delano (ServRX Inc.); Randall Prust, M.D. (Rincon Pain & Spine); Eileen Muro (Palo Brea Pain & Rehab); Marc Osborn (PCI); Deb Baker (Valley Schools); and Ellen Poole (American Insurance Association) addressed the Commission.

A written transcript of the Public Hearing is attached hereto.

Chairman Schultz closed the public hearing, noting that written comments will be accepted until close of business on September 13, 2018. Chairman Schultz recessed the meeting at 2:26 p.m.

The Commission meeting reconvened at 2:35 p.m. in Conference Room 308. Also present were Jose Soto and Mayra Rivas (Burlingame Industries Incorporated); Nat Carroll and Khalliduh Simon (Fondomonte Arizona, LLC); Tom Rowe, Nefi Munoz, and Anna Castro (ANM Enterprises, Inc.); and Michael Fassett (Snell & Wilmer).

Approval of Minutes of August 23, 2018 Regular Meeting.

Commissioner Krenzel moved to approve the minutes of the August 16, 2018 regular session meeting and Commissioner LeMarr seconded the motion. Chairman Schultz, Vice Chairman Hennelly, Commissioner LeMarr, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Consent Agenda:

All items following under this agenda item are consent matters and will be considered by a single motion with no discussion unless a Commissioner asks to remove an item on the consent agenda to be discussed and voted on separately. The Commission may move into Executive Session under A.R.S. § 38-431.03(A)(2) to discuss records exempt by law from public inspection. Legal action involving a final vote or decision shall not be taken in Executive Session. If such action is required, then it will be taken in General Session.

a. Approval of Proposed Civil Penalties Against Uninsured Employers.

1. 2C-17/18-0749 – Continuum Consulting, Inc.

b. Approval of Requests for Renewal of Self-Insurance Authority.

1. Freeport McMoran, Inc.

Vice Chairman Hennelly moved to approve the items on the Consent Agenda and Commissioner Krenzel seconded the motion. Chairman Schultz, Vice Chairman Hennelly, Commissioner LeMarr, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Discussion and Action of Arizona Division of Occupational Safety and Health Proposed Citations and Penalties.

Chairman Schultz discussed the purpose of and process for the Commission's consideration of ADOSH citations and proposed penalties.

Burlingame Industries Incorporated dba
Eagle Roofing Products
4602 W Elwood St.,
Phoenix, AZ, 85043

Referral
Years in Business: 18
Empl. Covered by inspection: 20

Site Location: 4602 W Elwood St.
Phoenix, AZ 85043
Inspection No: W0250 - 1301654
Inspection Date: 03/15/2018

SERIOUS – Citation 1 - Item 1 –

- a) Line 10, Wet and Dry station: Employees were exposed to the Tile Machine, model and serial numbers unknown, cutting head that lacked an adequate guard. 29 CFR 1910.212(a)(1)
Div. Proposal - \$2,250.00 Formula Amt. - \$2,250.00

SERIOUS – Citation 1 - Item 2 –

- a) Line 10, Wet and Dry station: Employees were exposed to unguarded rotating chains and sprockets of the Tile Machine, model and serial numbers unknown.
- b) Line 11, Wet and Dry station: Employees were exposed to unguarded rotating chains and sprockets of the Tile Machine, model and serial numbers unknown. 29 CFR 1910.219(f)(3)
- | | |
|----------------------------|---------------------------------|
| Div. Proposal - \$5,000.00 | Formula Amt. - \$2,250.00 |
| TOTAL PENALTY - \$7,250.00 | TOTAL FORMULA AMT. - \$4,500.00 |

Mr. Atencio noted this matter was previously discussed at the August 10, 2018 Commission meeting, was remanded to ADOSH for further review, and additional information was being provided for the Commissioners to consider. Mr. Atencio discussed ADOSH's investigation and summarized the citation and proposed penalties.

Chairman Schultz and Mr. Soto discussed abatement of all items and re-training of employees and their safety program.

Commissioner Krenzel moved to approve the citation and penalties as presented and Vice Chairman Hennelly seconded the motion. Chairman Schultz, Vice Chairman Hennelly, Commissioner LeMarr, and Commissioner Krenzel voted in favor of the motion. The motion passed.

Fondomonte Arizona, LLC
44376 Vicksburg Rd.,
Salome, AZ 85348

Referral
Years in Business: 4
Empl. Covered by inspection: 100

Site Location: 44376 Vicksburg Rd.,
Salome, AZ 85348
Inspection No: W0250 - 1301217
Inspection Date: 03/14/2018

SERIOUS – Citation 1 - Item 1 –

- a) Hay Press Machine 1: Two employees walked along the top of a 7ft 3in Hay Press, model #3546 and serial #C790214 without fall protection. 1910.23(c)(1)
- | | |
|----------------------------|---------------------------|
| Div. Proposal - \$2,250.00 | Formula Amt. - \$2,250.00 |
|----------------------------|---------------------------|

SERIOUS – Citation 1 - Item 2 –

- a) Hay Press Area: Two employees had been trained in LOTO, however the procedures were not followed by management and employees when retrieving tools from the top of the operating hay press machine. 29 CFR 1910.147(c)(7)(i)
- | | |
|----------------------------|---------------------------------|
| Div. Proposal - \$5,000.00 | Formula Amt. - \$2,250.00 |
| TOTAL PENALTY - \$7,250.00 | TOTAL FORMULA AMT. - \$4,500.00 |

Mr. Atencio noted this file was previously discussed at the August 10, 2018 meeting, was remanded to ADOSH, and that the file had been reviewed by ADOSH. Mr. Atencio discussed ADOSH's investigation and summarized the citation and proposed penalties.

Mr. Carroll discussed the company's response to the incident, including abatement and increased training. He discussed the company's SHARP certification and safety training program.

Commissioner LeMarr moved to approve the citation and proposed penalties as presented. Commissioner Krenznel seconded the motion. Chairman Schultz, Vice Chairman Hennelly, Commissioner LeMarr, and Commissioner Krenznel voted in favor of the motion. The motion passed.

ANM Enterprises, Inc. dba ANM Roofing & Stone
7805 E. Paloma Ave.,
Mesa, AZ 85212

Unprogrammed Related
Years in Business: 16
Empl. Covered by inspection: 4

Site Location: 2005 N. 103rd Ave.,
Avondale, AZ 85392
Inspection No: W0250 - 1309372
Inspection Date: 04/13/2018

REPEAT-SERIOUS – Citation 1 - Item 1 –

- a) 2005 N. 103rd Ave., Avondale, AZ: Four employees were installing concrete tile on a new two-story apartment complex and were exposed to a 30 foot fall to the ground below. 29 CFR 1926.501(b)(10)

ANM Enterprises, Inc., dba ANM Roofing & Stone was previously cited for a violation of this occupational safety and health standard or its equivalent standard 1926.501(b)(10), which was contained in ADOSH inspection number 1244053, citation number 1, item number 1 and was affirmed as a final order on 03/06/2018, abatement completed on 06/23/2017 with respect to workplace located at 4007 E. Indianola Ave., Phoenix, AZ, 85018.

ANM Enterprises, Inc., dba ANM Roofing & Stone was previously cited for violation of this occupational safety and health standard or its equivalent standard 1926.501(b)(10), which was contained in ADOSH inspection number 1121477, citation number 1, item number 1 and was affirmed as a final order on 06/04/2016, abatement completed on 01/29/2016 with respect to a workplace located at 36457 N. Gantzel Rd., San Tan Valley, AZ, 85142.

Div. Proposal - \$5,000.00

Formula Amt. - \$5,000.00

REPEAT-SERIOUS – Citation 1 - Item 2 –

- a) 2005 N. 103rd Ave., Avondale, AZ: Fall protection training was not provided for three employees who were exposed to fall hazards. 29 CFR 1926.503(a)(1)

Div. Proposal - \$1,000.00

Formula Amt. - \$1,000.00

TOTAL PENALTY - \$6,000.00

TOTAL FORMULA AMT. - \$6,000.00

Mr. Atencio discussed ADOSH's investigation and summarized the citation and proposed penalties. He noted that Citation 1, Item 1 should reflect a formula amount of \$1,000, after adjustment factors, and a Division proposal of \$2,000, based on the repeat nature of the citation.

Chairman Schultz and Mr. Rowe discussed safety issues and best practices with goals to reduce injuries.

Vice Chairman Hennelly moved to approve the citation and proposed penalties (total of \$3,000) and Commissioner Krenznel seconded the motion. Chairman Schultz, Vice Chairman Hennelly, Commissioner LeMarr, and Commissioner Krenznel voted in favor of the motion. The motion passed.

Discussion and/or action regarding Industrial Commission goals, objectives and key initiatives for 2018. This Agenda Item may include discussion regarding the Commission budget and review of Division, Department, and Section specific objectives.

Director Ashley discussed the Benchmark AMS Visit with representatives of Arizona Department of Juvenile Corrections, Arizona Game and Fish Department, and Arizona State Parks. He noted that another Benchmark AMS Visit is scheduled with the Arizona Health Care Cost Containment System.

Director Ashley discussed the volume of new applications for self-insurance that the Commission receives per year and the processing time for new applications. He noted that there are currently 79 self-insured entities in the state. Chairman Schultz pointed out the experience modification factors for self-insureds are generally much better than the average for the industries in which they operate.

Announcements, Scheduling of Future Meetings and Retirement Resolutions.

Ms. Dimas presented a retirement resolution for Robert Brooks, ADOSH Elevator Inspector, for 18 years of state service.

Ms. Dimas confirmed Commission meeting dates through October 2018.

Public Comment.

There was no public comment.

Vice Chairman Hennelly moved to adjourn and Commissioner Krenzel seconded the motion. Chairman Schultz, Vice Chairman Hennelly, Commissioner LeMarr, and Commissioner Krenzel voted in favor of the motion. The meeting was adjourned at 3:12 p.m.

THE INDUSTRIAL COMMISSION OF ARIZONA

By


James Ashley, Director

ATTEST:


Kara Dimas, Commission Secretary

THE INDUSTRIAL COMMISSION OF ARIZONA
MEDICAL RESOURCE OFFICE

REPORTER'S TRANSCRIPT OF PROCEEDINGS:

Public Hearing on Laws 2018, Chapter 101,
Section 3 (Senate Bill 1111)

Phoenix, Arizona
August 23, 2018
1:00 p.m.

Reported by:
Marla F. Knox, CR, RPR, CRR
Certified Court Reporter
Certificate No. 50870

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16	Mr. James Ashley, Director	
17	Mr. Joseph N. Henelly, Junior, Vice Chair	
18	Mr. Dale Schultz, Chairman	
19	Mr. Steven J. Krenzel, Commissioner	
20	Mr. Jason M. Porter, General Counsel	
21	Mr. Gaetano Testini, Chief Legal Counsel	
22	Mr. Scott P. LeMarr, Commissioner (telephonically)	
23		
24		
25		

Phoenix, Arizona
August 23, 2018

P R O C E E D I N G S

CHAIRMAN SCHULTZ: I would like to call this meeting of the Industrial Commission to order, and I would like to start with the pledge of allegiance, please.

(Whereupon, a brief pause was had.)

CHAIRMAN SCHULTZ: I'm Dale Schultz, and I'm Chairman of the Commission; and I would like to have -- introduce everyone else at the table here. James.

MR. ASHLEY: James Ashley, Director.

MR. HENNELLY: Joe Hennelly, Commissioner.

MR. KRENZEL: Steve Krenzel, Commissioner.

MR. PORTER: Jason Porter, Deputy Director.

MR. TESTINI: Gaetano Testini, Chief Legal Counsel.

CHAIRMAN SCHULTZ: And on the phone we have.

(Inaudible.)

CHAIRMAN SCHULTZ: Mr. LeMarr, are you there?

MR. LEMARR: Yes, I'm here.

CHAIRMAN SCHULTZ: Thank you. Very good. We also have a couple of call-in attendees that have joined us, and could you please introduce yourselves.

Kevin? He may not have joined us.

1 Alan? Okay. He may not have joined us.

2 So, good afternoon. Welcome to this public
3 hearing regarding medications dispensed in settings that
4 are not accessible to the general public.

5 By way of summary, earlier this year
6 Arizona lawmakers passed Senate Bill 1111. Section 3 of
7 Senate Bill 1111 stated: On or before July 1st, 2019, as
8 a part of the Industrial Commission of Arizona's Annual
9 Review of the Schedule of Fees pursuant to Section 23-908
10 A.R.S. as amended by this act, the Industrial Commission
11 shall review information and data; consult with physician,
12 employee, business and industry stakeholders and hold at
13 least one public hearing in considering whether to adopt
14 additional reimbursement guidelines for medications
15 dispensed in settings that are not accessible to the
16 general public.

17 In addition, A.R.S. 23-908 was amended to
18 give the Commission authority to include reimbursement
19 guidelines in the Arizona Physician's and Pharmaceutical
20 Fee Schedule for medications that are dispensed in
21 settings that are not accessible to the general public.

22 Following the passage of Senate Bill 1111,
23 the Commission began reviewing information and data
24 regarding the dispensing of medications in settings that
25 are not accessible to the general public.

1 The Commission retained PCG Health, a
2 leading public sector consulting and operations
3 improvement firm, that partners with governmental health
4 agencies to review available information and data related
5 to the topic of physician dispensing and to prepare a
6 white paper that summarizes relevant issues and practices
7 in other states. The white paper was publicly posted to
8 the Medical Resource office web page in advance of this
9 public hearing.

10 In addition to efforts to review relevant
11 information and data, the Commission has consulted with
12 the various stakeholders in an effort to better understand
13 the issues.

14 We now welcome you to present your oral
15 comments regarding the issues of medications dispensed in
16 settings that are not accessible to the general public.

17 Those wishing to speak may do so by filling
18 out a speaker slip, which is available both inside the
19 door and outside the door. I will call each speaker who
20 will have five minutes to speak.

21 Please note that at this time the
22 Commission has not made any decisions and is not proposing
23 any particular reimbursement guidelines related to
24 medications dispensed in settings that are not accessible
25 to the general public.

1 Although the public hearing will end when
2 oral comments have concluded, written comments will be
3 accepted through close of business on September 13th,
4 2018 -- important date -- September 13, 2018.

5 Once the record is closed, the Medical
6 Resource office will carefully consider all public
7 comments and available information and data and will
8 prepare -- propose reimbursement guidelines in conjunction
9 with the process of updating the Arizona Physicians and
10 Pharmaceutical Fee Schedule. These proposals will be
11 publicly posted, and the Commission will schedule another
12 public hearing to receive additional comments.

13 With that, we now open the floor to public
14 comment; and we will begin with a presentation from our
15 consultants, PCG, on the issues.

16 By the way, all comments -- both made here
17 and written comments -- will be posted to the website and
18 available for everyone to see. Go ahead.

19 MR. JONES: Good afternoon, Commission, and good
20 afternoon, Everyone. Thank you for attending. Again, my
21 name is Coy Jones. I'm with Public Consulting Group, and
22 my colleague, Nile Kazimer and I, will be going over some
23 of our findings from reviewing work in other states around
24 physician dispensing.

25 The -- as Chairman Schultz mentioned, this

1 is part of an ongoing effort to look at the issues around
2 physician dispensing as well as work we have been doing
3 with the Commission around reimbursement and fee schedule
4 regulation and to see what role the fee schedule and
5 reimbursement might have on this issue.

6 Today we want to present some of the issues
7 that we have seen in physician dispensing generally as
8 well as, you know, specific to the workers' compensation
9 space and any kind of evolving set of best practices, both
10 generally and in relation to workers' compensation in
11 particular.

12 So, again, I'm just very quickly going to
13 go over the overview and objectives that Chairman Schultz
14 mentioned. Talk about the facts a little bit, very high
15 level background of what is involved in physician
16 dispensing, and then Nile will go into the specifics
17 around workers' compensation, cost concerns, and perceived
18 public health impacts. And then -- then I believe there
19 will be some additional presentations.

20 So overview and objectives. Again, this is
21 a part of the legislative mandate to pursue and consider
22 potential reimbursement guidelines; and we have really
23 been tasked in three different aspects of our white paper.
24 One is to just present the issues that have emerged in
25 physician dispensing -- both pros and cons -- to try to

1 develop a comprehensive picture of what is at stake in
2 this issue, health implications as well as issues around
3 cost containment.

4 Another piece of our scope has been to
5 provide a detailed analysis on the impacts of State
6 reforms. So Arizona is not the first to tackle this
7 issue, and it will not be the last state. In workers'
8 compensation system there have been a number of states
9 that have -- where this issue has been raised in various
10 attempts to regulate physician dispensing. So, you know,
11 we have done intrastate comparisons, pre and post reform,
12 what was done, what has happened as a result, as well as
13 comparisons among states that have addressed this issue in
14 some ways and states that have not addressed it and the
15 outcomes in those different places.

16 The third part of our white paper, which we
17 have not done yet, is to develop policy recommendations
18 and options based on our understanding of what the
19 industry looks like and other state efforts, what is most
20 applicable to Arizona, what is in the best interest of the
21 system. So as a piece of that, we are rounding up our
22 best practices. We are rounding up the lessons learned
23 from other states, and we are taking in feedback from
24 public hearing. So we -- when we do that third part of
25 our white paper, you know, we intend to incorporate the

1 feedback both in support of the position of dispensing
2 practices and also those stakeholders who have raised
3 concerns about at least certain aspects of physician
4 dispensing and generate some findings and recommendations
5 based on all those kind of sources of data.

6 Again, reiterating that we are not there
7 yet. So we are presenting the issues as we seen them in
8 the best practices. Make it very clear what we are
9 looking at, and we very much value your feedback and -- in
10 terms of identifying what is not at issue for Arizona,
11 what is an issue for Arizona; and we do hope to
12 incorporate that in our final white paper.

13 So what are we doing here today? Other
14 than presenting, we are receiving input and information
15 concerning the issues of physician dispensing. Again,
16 reminding you that September 13th is a very important date
17 to get written and oral comments on the issue in, and then
18 the plan -- the plan as we understand it is the action
19 taken by ICA will be proposed in the 2019/2020 fee
20 schedule staff proposal recommendations document, and the
21 plans are to be posted in April of 2019. I believe there
22 will be some additional opportunities to provide comment
23 as the process evolves.

24 Just to give you an overview of physician
25 dispensing -- not necessarily in workers' compensation

1 alone -- but an overview and orientation of the issue in
2 general. It is the practice in which clinicians dispense
3 medications directly to patients out of their offices; and
4 as part of the service, physicians earn some revenue from
5 prescribed -- prescribing medications inhouse. So this is
6 a practice that is permitted in Arizona provided that the
7 dispensing physician registers with the Arizona Medical
8 Board. There are certain regulatory requirements around
9 disclosure, storage, data entry, labeling rules; and then
10 physician dispensing is one of those practices of
11 self-referral that is exempted from Stark Law.

12 Why is this an issue? What is at stake
13 here? Why does it come before the attention of the
14 Commission and Legislature? Well, in general -- not just
15 in workers' compensation -- but in other areas of the
16 healthcare sector, it has become a major contributor to
17 increasing prescription drug costs, particularly in
18 workers' compensation.

19 In workers' compensation physician
20 dispensing can account for over 60 to 300% of the increase
21 in prices paid for commonly prescribed medications in
22 comparison to retail pharmacies. The practices have
23 raised concerns about adverse drug events, surveillance as
24 well as opioids use. As you all know most likely, this is
25 a part of a broader set of initiatives undertaken by the

1 State to deal not only with the cost containment issue but
2 with opioid use and other forms of drug surveillance.

3 So in terms of how the -- there are a
4 number of different camps on physician dispensing. Many
5 in favor. Many in opposition. What we have done in our
6 white paper is sort of roundup some of those pros and
7 cons. Again, not necessarily coming to any conclusions on
8 which of these are legitimate and illegitimate arguments;
9 but putting things out in terms of a roundup of arguments,
10 these are the sorts of arguments that are generally put
11 forward in support of a particular position.

12 I will go through the proponent arguments
13 first. Again, this is not necessarily specific to
14 workers' compensation. First, is physician dispensing
15 ensures or helps to ensure medication initiation,
16 adherence and compliance. It's really kind of closer to
17 the treatment and being connected with the physician,
18 which helps to ensure medication adherence in particular.

19 The point -- it's also suggested the point
20 of care access to medications will reduce some of the
21 geographic barriers in remote areas. It supports -- it is
22 yet another avenue for access to medications and supports
23 access to care in general.

24 Another argument put forward is the ability
25 to obtain medications at the point of care increases

1 patient satisfaction, and that there is an overall
2 reduction in overhead costs, in reduced need to
3 communicate with pharmacies. So there is some
4 care/coordination issues that are represented. Then a
5 reduced likelihood of communication errors due to
6 decreased need to relay information to pharmacies; and
7 finally, it is seen as a vital source of extra revenue.

8 Now, on the side of opposition, many people
9 claim that overpriced medications -- that they become
10 overpriced when they are dispensed by physicians rather
11 than pharmacies, and that those drive prescription costs.
12 That there is an increased likelihood that
13 over-the-counter medications will be prescribed at a
14 higher cost under physician dispensing, and that it
15 circumvents public health surveillance systems that rely
16 on centralization and prescription data. And then,
17 finally, the physician dispensing undermines the
18 mechanisms designed to identify drug safety issues,
19 narcotics abuse, abuse of diversion and duplicate
20 therapies.

21 So that's really kind of a landscape
22 overall. Workers' compensation is a very unique space in
23 the healthcare sector. I'm going to turn it over to Nile
24 to kind of talk about what are the real salient issues in
25 this particular industry.

1 MS. KAZIMER: Good afternoon. My name is Nile
2 Kazimer. I'm a consultant with the Public Consulting
3 Group. Today I will go over the issues specifically under
4 the lens of workers' compensation, the implications that
5 the practice have on the cost in this area in particular;
6 and I will be citing several statistics and findings from
7 the WCRI and the NCCI.

8 So with regards to the physician dispensing
9 and workers' compensation, one of the biggest topics that
10 has been raised in numerous studies is this use of
11 financial incentives versus medical necessities. As far
12 as research by the WCRI, the Workers' Compensation
13 Institute, from 2007 to 2011, they looked at prescription
14 data nationwide. I believe they included 20 states in
15 their analysis, and they found that there was a rapid
16 growth in physician dispensed pharmaceuticals under
17 workers' compensation; and that the prices of physician
18 dispensed medications are much higher than that of
19 pharmacies and that in 13 of the 20 states that they have
20 examined, 1 in 6 prescriptions were physician dispensed.
21 And in the states listed there -- California, Florida,
22 Illinois, Georgia and Maryland and Arizona -- that is 1 in
23 3. That is more recent data from 2010 to 2011.

24 And among states where physician dispensing
25 was common, there was a higher percentage of injured

1 workers being prescribed medications that are rarely
2 dispensed in states where this practice is less common.
3 Common drugs prescribed under workers' compensation are
4 targeted for reformulations that are higher priced and
5 able to bypass numerous pricing regulations that are based
6 on original formulations of that drug.

7 Now, what this shows is that the pricing
8 regulations that have been in place that deem that
9 physician dispensing have been shown to alter prescribing
10 patterns, particularly in workers' compensation, and that
11 the practice is prone to perhaps monetary influence rather
12 than medical necessity alone because we do see that in
13 states where physician dispensing is less common. Certain
14 types of drugs are dispensed at a reduced rate, at a rate
15 that is statistically significant and different.

16 As far as diving into some of the specific
17 proponent points that Coy raised about the four camps for
18 physician dispensing, one of the main arguments was that
19 the practice allows for access to medications at the point
20 of care right when patients are there with their doctors.
21 That is true and that has merits in so many ways.

22 However, there has been absolutely no
23 research that we found up-to-date that specifically
24 quantifies the health outcomes that have come with that in
25 a positive light. There is -- there is also this idea

1 that physician dispensing in workers' compensation allows
2 injured workers to bypass some of the very complex and
3 existing bureaucracy issues when it comes to obtaining
4 medications, and that is true. However, there is also no
5 research so far to quantify this section of this issue.
6 What does that mean? That means there has been no
7 research that shows exactly how long is this delay and
8 what is the impact of this bureaucratic delay and what
9 impact that has on health outcomes.

10 To date, there has been two studies that
11 actually have shown that physician dispensing in certain
12 medications that are prescribed under physician dispensing
13 actually has adverse health outcomes, implications; and we
14 will go over that here in a few minutes.

15 The second issue that is raised by
16 proponents of physician dispensing includes this idea that
17 the practice allows initiation and adherence. Physician
18 dispensing has -- does provide medications at the point of
19 care. However, peer-reviewed research on this topic
20 reveals wide variations in initiation and adherence rate
21 and depends on the kinds of medications that are
22 prescribed at the point of care.

23 For workers' compensation, the bulk of the
24 medications that are prescribed under the program are pain
25 medications. When we looked at data that pertains

1 specifically to pain medications, we found that adherence
2 to pain meds is much less of an issue than compared to,
3 say, adherence to diabetes management medications or
4 cardiovascular health management medications.

5 Research on medication adherence also is
6 often focused on maintenance medications rather than for
7 chronic diseases, rather than acute work-related diseases.
8 Adherence can also refer to a variety of things; that is,
9 underuse, overuse or misuse of the medications altogether.
10 So in order to better explore this topic, we need to
11 further define what we are looking at. Are we looking at
12 underuse of medications, overuse, or use of medications
13 for instances that it was not prescribed? Most
14 prescriptions in workers' compensation, like I said, are
15 for pain medications; and therefore, compliance has been
16 shown to be less of a concern.

17 Now, we will go into cost concerns. For
18 this, I would first like to introduce this idea of
19 repackaging. Repackaging has been attributed to be the
20 major cost driver in prescription costs under physician
21 dispensing due to this idea that the medication is removed
22 from its original container and put into new containers
23 with higher prices. Basically, the drug itself has not
24 changed but the price tag has in the process. And until
25 recent reforms, repackaging was a significant cost driver

1 because a new national drug code, a new NDC, was given to
2 these repackaged medications, which does not appear on
3 existing fee schedules which allow for higher
4 reimbursement rates.

5 Another area of concern is unmanaged
6 prescriptions, which physician dispensing falls under.
7 They refer to prescriptions that are prescribed outside of
8 your traditional mail-in order pharmacies or retail
9 pharmacy networks. There is a disproportionate amount of
10 unmanaged prescriptions within workers' compensation
11 making the system more fiscally vulnerable for the
12 following reasons: The first is that physician dispensing
13 bypasses the traditional cost and inventory control
14 applied by networks that make up pharmacy benefits before
15 prescriptions are dispensed. These are usually negotiated
16 rates that are not inherent in physician dispensing today.

17 Physician dispensing as a practice does not
18 employ rigorous formulary enforcement, thus decreasing the
19 generic efficiency, which can be a significant cost
20 driver. Generic deficiency here refers to the proportion
21 of overall prescribed medications that are the generic
22 equivalence of a brand counterpart. So how efficiently is
23 the system able to pick a generic medication over a
24 branded version that is often times at a much higher cost?
25 And basically the point is saying that under physician

1 dispensing, branded version is the go-to option.

2 Physician dispensing does not allow for the
3 necessary data sharing systems in which pharmacies have in
4 place to track real-time data associated with various
5 injured worker populations. This has wide ranging
6 implications in utilization costs as well as health
7 outcomes, and we will go over this in detail in a few
8 slides.

9 I have a few examples here from the WCRI.
10 This is from their 2010 to 2011 data. It specifically
11 pertains to the medication Vicodin and Mobic. For
12 Vicodin, they found that average price per pill under
13 physician dispensing nationwide was 100 to 300 times
14 higher than the price paid for the same medications by
15 pharmacies.

16 When California and Georgia implemented
17 pricing reforms targeted at this markup, they found that
18 that dropped to about 19% and 67% respectively. For
19 Mobic, the average price per pill paid per physician
20 dispensed medication was 40 to 220 times higher than that
21 of the same drug dispensed by pharmacies. There is a lack
22 of medical evidence here as well that suggests that Mobic
23 is more effective than ibuprofen which is a much cheaper
24 counterpart.

25 Furthermore, the rapid growth of Mobic

1 prescription coming from physician offices in the states
2 where physician dispensing is common, such as Illinois,
3 they found that 80% of all meloxicam prescribed in that
4 state were dispensed by physician; and this is this figure
5 of 80% or above and is not found in states where physician
6 dispensing is less of a common practice.

7 Here is case study as well. We picked out
8 this one given the implications that it has both on
9 pricing itself and on public health concerns. So among
10 states where physician dispensing is common prior to
11 reforms -- in Florida, Georgia, Illinois and Maryland --
12 8 to 11% of injured workers were prescribed omeprazole or
13 Zantac or both. The average price per pill paid under
14 physician dispensing in these states were as much as twice
15 higher than prices paid for -- in states where physician
16 dispensing is less common, and these two medications are
17 rarely prescribed in states where physician dispensing was
18 less common.

19 And now we will move onto the public health
20 impacts and implications of physician dispensing. So we
21 have looked at peer review research on this. We ventured
22 out into research surrounding healthcare IT and
23 interoperative issues and the idea of dataflow, and we
24 found that physician dispensing have public health
25 implications particularly when it comes to drug

1 surveillance. So with the practice at its current state
2 and where we are today with our health IT systems, it
3 really prohibits rigorous public health surveillance and
4 monitoring of medication usage and drug interactions.

5 In physician offices data is still often
6 siloed and data sharing is still incredibly hard to occur;
7 and numerous research that shows nationwide this remains
8 an issue today even with the implementation of the
9 electronic health records.

10 Pharmacies are better able to provide
11 medication oversight and utilization reviews given their
12 one-to-many relationships they have with multiple
13 providers feeding in this information to a centralized
14 data system that gives them the greater visibility to see
15 across multiple physicians and across multiple practices
16 for that same patient.

17 Prescription centralization entities, like
18 I said, they are able to track and look at population
19 health level data; and they are able to respond in a more
20 real-time manner relying less on data feedback from these
21 silo systems.

22 With opioids, the National Council on
23 Compensation Insurance, NCCI, have conducted research on
24 this and have found that for opioids such as Oxycontin,
25 Oxycodone and Acetaminophen they were among the most

1 widely prescribed drugs in workers' compensation as recent
2 at 2014.

3 During that same year, data from the WCRI
4 shows that physician dispensed drugs and controlled
5 substances grew faster than any other category of
6 prescription drugs. In 2018 WCRI released a report
7 earlier this year that actually showed excessive opioid
8 prescription led to longer duration of temporary
9 disability benefit claims.

10 Certain states have prohibited physician
11 dispensed opioids altogether; that being Florida where
12 Schedule 2 substances are now completely banned for
13 physician dispensing, and physician dispensing has been
14 shown to encourage opioid prescriptions in numerous
15 studies by the NCCI and the WCRI.

16 Now, that we set up the issues we can
17 dissect as far as cost concerns and public health
18 concerns, we will move into what have states done to
19 address this issue, the regulatory approaches that have
20 been taken and the lessons that have been learned. This
21 is by no means a comprehensive list. These are the major
22 sort of targets that states have used to address the
23 issues of physician dispensing.

24 The first tool that employed pricing
25 reforms and regulations -- one of which Arizona has

1 already adopted parts of it -- requiring parity in fee
2 schedules between pharmacies and physician dispensaries,
3 often determined by the average wholesale price -- Arizona
4 currently requires that the average wholesale price of the
5 original manufacturer's drug is used rather than any
6 repackaging at original wholesale price.

7 The second part is require that medications
8 be billed under the original national drug code and not
9 the new national drug code that may have been obtained
10 under repackaging, and the third is limit or prohibit of
11 the dispensing fee altogether. Currently Arizona
12 charges -- allows for a \$7 dispensing fee.

13 The second means has been licensing and
14 reporting requirements, so the use of medical boards and
15 boards of pharmacies. Arizona currently requires that
16 physician dispensed entities register with the Arizona
17 Medical Board; that registration and licensing requirement
18 also is with the DEA for narcotics dispensaries.

19 The third main approach has been to
20 regulation, regulate supply and dosages, how much of a
21 medication is allowed and for how long. Prohibition and
22 restrictions on medications that are susceptible for abuse
23 has been particularly targeted under this option. The
24 main ones that have we have been seen has been restriction
25 on dosage and supply.

1 The last one is restriction on credentials
2 of those allowed to dispense medications, and this
3 pertains to physician assistants, nurse practitioners,
4 limiting the scope at which they can make that
5 determination and dispense medications.

6 And to further continue exploring
7 regulatory approaches in this space, states with the
8 strictest physician dispensing regulations include but are
9 not limited to the states listed there.

10 Utah only allows physicians to dispense
11 certain drugs at employer-sponsored clinics. They took
12 the most restrictive approach to allowing this practice.
13 Texas only permits dispensing to meet patients' immediate
14 needs in rural areas. They keep the access or benefits
15 for patients here but haven't taken a very restrictive
16 approach otherwise. Massachusetts only permits
17 dispensation of drug samples. Florida prohibits
18 physicians from dispensing 2 and 3 controlled substances
19 in all instances, and California has reforms that require
20 preauthorization of certain drugs under their established
21 medication and also includes regular enforcement of a
22 formulary that they are very strict about.

23 So we picked two states that have done the
24 most work in their reforms targeting physician dispensing,
25 and that is California and Florida. California began a

1 series of reforms starting in 2007 which required that fee
2 schedules for physician dispensed drugs be based on the
3 original manufacturer's NDC. That was their first step to
4 addressing this issue. Arizona has also adopted this
5 policy in recent years, and the key findings from their
6 initial reforms to now are as follows:

7 First, is that price reduction did not
8 result in lower prescription. This suggests that
9 patients' access to medications were not interrupted.

10 Second is that less prepackaged drugs were
11 dispensed cheaper and non-repackaged drugs were dispensed
12 instead. There was also a decrease in frequencies of
13 prescription drugs associated with higher than usual
14 consumer prices under physician dispensing. In instances
15 where physicians stopped dispensing in response to that
16 price reduction and price control, pharmacies were able to
17 compensate and do so at a lower price.

18 Florida Senate Bill 662 required that all
19 prepackaged medications dispensed at physicians' offices
20 be reimbursed at 112.5% of the average wholesale price as
21 determined by the original manufacturer's NDC. The reform
22 had little impact on the number of dispensing physician
23 practicing dispensing but caused a decline in the number
24 of prescriptions instead.

25 The key finding from Florida reforms are as

1 follows: The first is that prices of common physician
2 dispensed drugs declined by 19 to 41% even though prices
3 paid to pharmacies during that period remained constant or
4 increased. Cost savings were, however, off-set by
5 introductions of new strength products at higher prices.
6 So what does this mean? It meant that 4 of the top 10 of
7 the most frequently dispensed drugs, which made up 16% of
8 the total physician dispensed medications, saw that 19 to
9 41% decline in price. However, that reduction was off-set
10 by a 63 to 66% increase in prices of two medications that
11 make up 24% of the total medications prescribed. So they
12 achieved cost savings due to pricing restrictions, but
13 that was off-set by these two medications that make up the
14 bulk of the total prescription.

15 The 112.5% of AWP, allowance that they put
16 forth, plus an \$8 dispensing fee for reform, may have
17 actually contributed to pricing increase in several of the
18 medications prior to the reform had prices that were lower
19 than 112.5%. So they were kicking the prices up to meet
20 that 112.5% threshold.

21 Specifically for Arizona, Arizona clinics
22 that dispensed medication at the point of care to workers'
23 compensation patients are currently reimbursed on
24 calculations using the workers' compensation average
25 wholesale price based on the original manufacturer's AWP.

1 This has been somewhat circumvented by newer strength
2 formularies or different dosages that has a higher
3 original manufacturer's AWP. So much of this first point
4 has been off-set as well. The reimbursement schedule for
5 physician dispensing to workers' compensation patients is
6 85% of the manufacturer's AWP plus a \$7 dispensing fee
7 allowed. Medications here also include prepackaged
8 dispensable injection kits as well as compound topical
9 creams, which has been shown to have one of the highest
10 growth rates of prices currently.

11 Furthermore, I would like to point out the
12 steps that have been taken this year and the regulations
13 that have been passed in the State of Arizona to
14 specifically address the issue of opioids abuse and combat
15 the opioid epidemic.

16 First is SB 1001 that was passed in 2018,
17 earlier this year. This one -- for SB 1001 there was a
18 limit in initial prescriptions for Schedule 2 opioids to a
19 5-day supply or 14-day supply when it was related to
20 surgery. There are a few exceptions on that as well. A
21 prescriber may not issue a prescription for Schedule 2
22 opioids which exceeds 90MGs per day with exceptions as
23 well. It requires the dispenser to obtain a utilization
24 report from the State's prescription drug monitoring
25 program prior to dispensing a Schedule 2 controlled

1 substance, and all prescriptions must use electronic
2 prescription systems by 2019.

3 That last point particularly highlights
4 where we are today with regards to these systems, and the
5 full implementation of the systems has yet been realized.

6 With SB 1111 that was passed in April of
7 2018, it applies prescribing restrictions for doctors who
8 are providing opioid/analgesic treatment specifically to
9 injured workers. The applied provisions of SB 1001 to all
10 opioid and incorporation of language directly into
11 workers' compensation law. The bill enhances reporting
12 requirements and patient requirements that a provider must
13 provide in order to prescribe controlled substances. It
14 further requires prescribers to obtain patient utilization
15 report from the Prescription Drug Monitor Program, PDMP,
16 at least quarterly while treatment is ongoing and before
17 prescribing opioids or benzodiazapine, Schedule 2
18 substances. It also includes a key definition as newly
19 required in treatment reports mentioned above and a new
20 definition of what is considered traumatic injuries.

21 So the State of Arizona has very recently
22 implemented very rigorous reforms targeting specifically
23 opioids; however, much of the reform leaves out other
24 kinds of medications that are also very common in workers'
25 compensation; and that's what we are here to discuss.

1 That's it from us. I will be able to take
2 comments at the very end.

3 CHAIRMAN SCHULTZ: Please. Thank you Coy and
4 Nile. If you do have questions or comments from this
5 presentation or any of the other speakers, please hold
6 them to the end. We will give you an opportunity, but
7 that will help us eliminate cumulative questions. So
8 thank you for that.

9 Now we will have our next speaker, Gale
10 Vogler. When you come to the podium if you would please
11 introduce yourself, state your name and who you are
12 representing.

13 MR. VOGLER: Good afternoon. I'm Gale Vogler.
14 I'm with CopperPoint Insurance. I'm the director of
15 medical management at CopperPoint. I appreciate
16 everybody's time today; letting us come and speak on our
17 position regarding physician dispensing in Arizona.

18 CopperPoint urges the Commission to adopt
19 the reimbursement guidelines outlined in 2019/2020 Arizona
20 Physician and Pharmaceutical Fee Schedule. I'm going to
21 show some data on these slides that is pertinent to
22 Arizona. These are derived from our actual workers'
23 compensation claims handled at CopperPoint.

24 Our data shows in Arizona there is a very
25 small number of medical providers who are engaged in the

1 dispensing, and they drive tremendous profits at the
2 expense of the injured workers, their employers and the
3 workers' compensation system as a whole.

4 The data I'm showing is from July 15, 2017,
5 through July 15, 2018. During that time CopperPoint paid
6 29 different physician dispensers for medications costing
7 a total of \$2,194,437. And as you can see from the slide
8 up here, the top three dispensers were responsible for
9 over \$1.9 million worth of that spend.

10 This slide will show the breakdown of those
11 29 different prescribers. Significantly only 5 of the 29
12 dispensers were responsible for 95% of all the dispensing
13 costs.

14 Physician dispensing is not more convenient
15 to the injured worker especially after the first fill
16 situation. Physician dispensed refills require the
17 injured worker to attend another doctor visit typically
18 during business hours and/or on weekdays. By contrast
19 pharmacies available to the general public are often
20 available a lot of different hours. Some have 24/7 access
21 but definitely available before and after regular business
22 hours.

23 Some say that the physician dispensing
24 allows the injured employee to get their medications more
25 efficiently. We found the majority of CopperPoint injured

1 workers reside in areas with access to multiple pharmacies
2 within a short distance. In fact, most had upwards of 50
3 or more pharmacies within a 15-mile distance while others
4 in rural areas had at least 5 pharmacies in that range.

5 Most carriers also have the, what we call,
6 pharmacy benefit managers. Most of those pharmacy benefit
7 managers also offer mail order; pharmacy services that
8 deliver typically a 3-month supply of medications directly
9 to that injured workers' door.

10 I will show a couple slides on the cost
11 that we see from physician dispensing for medications
12 versus non-physician medications. Duloxetine,
13 30-milligram capsules -- as you can see on the slide --
14 during that time period, CopperPoint spent \$189,970 on
15 this specific drug through physician dispensing. With
16 that same amount of volume of drug through a retail
17 pharmacy, CopperPoint would have only spent \$3,596 on that
18 same medication. You can see there is a large financial
19 incentive in physician dispensing.

20 I have a couple other data points on a
21 couple different types of drugs. We see on this physician
22 dispensing we saw a charge for \$3,327 for a specifically
23 formulated Menthoderm Ointment when compared to a typical
24 muscle rub product that an injured worker can get over the
25 counter, that same product over the counter was \$52.61.

1 Obviously we are going back to this
2 Duloxetine per pill charge for special formulation of this
3 is about \$7.54 when physician dispensed. Typically
4 through a PBM we can get that same prescription at \$0.20 a
5 pill.

6 I will show a couple slides of what we see
7 is our average cost of claim. With physician dispensing
8 our average cost of claim -- this is medical and indemnity
9 cost -- \$4,280; and when physician dispensing is not
10 involved, that same claim will be \$2,370.

11 Average cost per scrip -- physician
12 dispensed versus pharmacy dispensed -- physician dispensed
13 per scrip of top three physician dispensers are \$546.
14 That same scrip dispensed by a retail pharmacy \$221.

15 What are CopperPoint's recommendations in
16 light of the concerns? We suggest the following concepts
17 as the Commission considers optimal reimbursement
18 guidelines for medications dispensed outside the pharmacy
19 setting: Any reimbursement restrictions should apply not
20 only to medications dispensed by physician in their
21 offices but to all medications dispensed in settings not
22 accessible to the general public.

23 Any reimbursements for medications
24 dispensed in non-pharmacy settings should be limited to
25 circumstances where all of the following apply:

1 Medications dispensed is not for more than an initial
2 one-time limited supply. We feel in the realm of about
3 14-day supply. Medication is dispensed with short period
4 after the injured employee seeks treatment; typically
5 within 72 hours we feel is sufficient, and that will give
6 them access to emergent circumstances. Medications formed
7 to formulas and dosages customarily available in a
8 pharmacy setting and available to the general public.

9 All in all CopperPoint believes that the
10 adoption of the reimbursement guidelines is essential to
11 the sustainable system that provides quality medical
12 treatment to the injured employees in a safe and cost
13 effective manner. That's all I have today. Thank you.

14 CHAIRMAN SCHULTZ: Thank you, Mr. Vogler, and we
15 truly appreciate the Arizona specific data. It is very
16 helpful. By the way, Mr. Vogler's information, as well as
17 all other written comments received, will be posted within
18 a very few days. Of course it takes a few days for IT to
19 get it posted on the Medical Resource Office website.
20 Everything we receive will be on that website. Thank you.
21 Our next speaker, Joe Falb.

22 MS. FALB: Hi, Mr. Chairman and Members of the
23 Committee, thanks for allowing us to speak today. My name
24 is Jill Falb, and I manage pharmacy benefits for CorVel
25 Corporation. CorVel is a national provider of workers'

1 compensation solutions for employers, third-party
2 administrators, insurance companies and government
3 agencies.

4 At the core of our offering as a PBM
5 manager is what we call prospective management. We firmly
6 believe that -- it is at the core of our belief that in
7 order to manage pharmacy benefits, they must be managed
8 safely. So we have gone through a lot of -- I have
9 listened, and it has been so informative about the cost
10 concerns with physician dispensing; and while they exist,
11 I want to focus a little bit more on the safety. I'm
12 going to do that by talking about how we manage pharmacy
13 benefits and the efforts that we go through with even
14 going through traditional pharmacy methods.

15 So what we feel is to effectively manage
16 workers' compensation prescriptions, it starts with a
17 strong clinically based formulary; and we can only create
18 that formulary with an integrated data set, with data
19 accumulated over the years with our experience.

20 They also -- medication should be
21 prospectively managed. That includes a rigorous,
22 comprehensive point of sale, DUR edits and clinical
23 review. So all medications need to stop at the point of
24 sale. I will give you an example. A Claimant, an injured
25 worker, will go to a pharmacy with a very common Z pack.

1 If they go to the pharmacy and present that Z pack, the
2 pharmacist will be able to look in his data; and it will
3 be flagged if he is taking a blood thinner. The
4 combination of these two medications are very, very
5 dangerous. So that -- that is an example of within the
6 physician dispensing arena, there is no access into that
7 information. The physician has to rely on the Claimant or
8 the injured worker to let them know what he is taking. So
9 this is stopped right at that point. They also screen for
10 issues with safe dispensing including drug interaction and
11 therapies.

12 So what our team does as we -- we take it a
13 few steps further. So we have created this formulary. If
14 a medication isn't on the formulary, it is stopped at the
15 point of sale. Stopped. We review for safety. A phone
16 call is made to our group. We have nationally certified
17 pharm technicians, and they take the call and ask very
18 important questions such as: Is this related to the work
19 comp injury. They access our data to look to see what
20 else has he been filling, what is his injury, what is his
21 diagnosis code, what are the notes on file, what is known
22 about this particular person. We arm our adjusters to
23 make good, safe decisions. This is all before the
24 medication is dispensed. We have access into all
25 medications that they are taking.

1 Now, this workflow can't be supported with
2 a physician dispensing model. That's a retrospective
3 model. So they are already out the door. Now, it is so
4 important to our team that a third of our department --
5 and I manage operations -- is called the unmanaged
6 dispensing team. So their sole focus is to take
7 medications out of network and bring them back in however
8 they can. We leverage our agreement with our pharmacy to
9 ensure that pharmacies are using pharmacy cards and
10 therefore applying formularies. We apply that. We
11 leverage our PPO agreement with prescribers. They agree
12 to a strict utilization review program that includes: Do
13 not dispense out of your office. It is not safe.

14 All of these factors are what we do; what
15 we feel we are doing it right when we do this. Now you
16 guys, as I said, talked about the financial impact on this
17 and that is significant; but we feel the safety is just as
18 significant.

19 I want to talk about some states that are
20 doing it right in my opinion. We work across the country
21 with all different states, and New York -- now, it is a
22 combination of a directed care program -- so they have
23 allowed their -- their PBM managers and payers to direct
24 care and say, you need to go through the pharmacy. You
25 need that safety net of a rigorous DUR process. That,

1 combined with the limited physician dispensing
2 regulations -- limited to a first fill -- and their
3 medical pharmacy to medical spend, which is a barometer or
4 metric in our industry to show what a ratio is -- that
5 pharmacy to medical spend went from 14.3% when it started
6 in 2015 to 7.7% in 2017. That is a significant drop. So
7 we know managed prescriptions are working and managed
8 programs. That's all I have.

9 CHAIRMAN SCHULTZ: Thank you. Emily Rice.

10 MS. RICE: Good afternoon. I'm Emily Rice with
11 B3 Strategies, and I'm representing the Arizona
12 Self-Insurers Association. Our membership includes some
13 of the largest private and public sector self-insurers in
14 the State. On behalf of ASIA, I want to thank you, the
15 Industrial Commission of Arizona, for your consideration
16 of this issue and development of reimbursement guidelines
17 for medications dispensed in settings that are not
18 accessible to the general public such as instances of
19 physician dispensed medications.

20 At the ICA's request for public comment
21 focused on data, I will be discussing instances where our
22 members have been able to share differences in costs and
23 prescribing behavior related to prescriptions in a pro
24 setting versus documented retail costs or other coverage
25 prescribing behaviors. This data comes from a public

1 sector organization and as of today funded by the Arizona
2 taxpayer.

3 This public self-insured saw cost
4 differences ranging from \$19.71 per prescription increase
5 from the retail price of Tramadol HCL to \$1,064.74 per
6 prescription increase from the retail price of Topiramate,
7 an anticonvulsive medication. From a percentage increased
8 perspective, this insurer saw increased costs for
9 physician dispensed medication ranging from 9% to 228% and
10 per pill cost increases ranging from \$0.30 per pill
11 increase to a \$12.17 per pill increase. In no instances
12 did this insurer see a cost savings related to physician
13 dispensed medications.

14 On average this Arizona public self-insurer
15 saw a 67% increase in costs related to physician dispensed
16 medications compared to retail costs within a five-month
17 period. These increased costs reflect the prescribing
18 behaviors of only three workers' compensation physicians
19 and related to prescription for 12 different medications.
20 For this insurer these doctors also prescribed well over
21 the average number of prescriptions per physician;
22 prescribing an average of 13 prescriptions per physician
23 compared to a system average of 4.26 prescriptions per
24 physician over a six-month period. While these doctors
25 represent only 2.5% of the total number of physicians that

1 this self insurer works with, they represent 8% of the
2 self-insurer's total prescriptions.

3 While the problems with physician
4 dispensing is relatively small in Arizona today, the 22
5 other states that have addressed the physician dispensing
6 saw the practice grow to the point of getting major
7 workers' compensation. In Illinois and Florida more than
8 50% of the workers' compensations prescriptions were
9 physician dispensed.

10 Based on national average, as we had
11 mentioned, drugs dispensed by physicians are typically
12 between 60 and 300% more expensive than those dispensed at
13 a retail pharmacy. With prescriptions also being the
14 largest cost for insurers, the need to control costs is
15 critical especially for tax payer organizations.

16 Although our health insurer provides a
17 small sample, it illustrates that this is an Arizona
18 problem that has fiscal and patient consequences; that if
19 left unaddressed, could drastically increase. The
20 physicians that this insurer works with dispense
21 medications prescribed approximately 30% more medications
22 than their system average and increase the self insurers
23 pharmacy cost by an average of 67%.

24 Identifying the depth and scope of this
25 issue early can help ensure patient, insurers and identify

1 taxpayer protections and circumvent this issue from
2 growing to the same magnitude by other states. Thank you
3 for your consideration of this issue.

4 CHAIRMAN SCHULTZ: Next speaker, Todd Delano.

5 MR. DELANO: Thank you, guys. Thank, everyone,
6 for your time. I think I can frame this -- first, I'm
7 Todd Delano. I'm the CEO of ServRX. We are a billing
8 firm. We represent -- we are contracted with well over
9 10,000 pharmacies around the country including physicians.
10 We manage thousands of accounts, thousands of doctors.
11 Yet 70 to 80% of our business is also traditional
12 pharmacies including some grocery store chains you would
13 recognize in this state. We do have a fairly
14 comprehensive list of clients and expertise and that is in
15 all 50 states as well although we are here in Scottsdale
16 where our corporate headquarters are.

17 You guys have a lot of information to sift
18 through; and for me to sit up here and give you too many
19 points or counterpoints, I don't think would do you a lot
20 of justice for my time here. I would frame this in a way
21 of looking at a continuum of healthcare. This is workers'
22 comp, and this is a healthcare situation we are trying to
23 discuss and solve. You can clearly make a line down the
24 middle, and you will hear from people on the payor/large
25 employer side; and you will hear from people from the

1 provider side; and if there was an axis to me, there is a
2 far extreme left side as well. So when you are in front
3 of a panel sometimes, your job is to pluck certain data
4 points. It will help you show the disparity of why your
5 point is right and why their point is wrong. To me it
6 does you a disservice because it is your job to sift
7 through what are the facts, where do things lie. So I
8 hope my job is to be a voice of reason. While I represent
9 the provider side, and predominantly on the network, I
10 want to be a voice of reasonableness to the panel and
11 hopefully to you guys in the coming weeks as you decide
12 what to do on this issue.

13 Let me first say that the study, the white
14 paper that was produced today -- I think it was noted by
15 Gale justifiably so -- and you mentioned that Arizona data
16 is most applicable to our discussion today. I won't
17 belabor the point, but the study was from 2011. The world
18 looks vastly different in 2018 even in the states
19 mentioned in the study; and specifically each state has
20 its own fee schedule, its own ecosystem, its own payor
21 mix; and therefore the data we should be focused on is
22 Arizona and how it impacts our community and our state.

23 Just to make few points, though, because
24 the white paper is a -- I would say a starting point for
25 you guys as a frame of reference -- the first topic of

1 compensation was with the overpriced medication. I think
2 it needs to be said. I'm not sure who understands the
3 information that was shared about the repackaging of
4 medication. First, let me say not an issue in Arizona to
5 be very clear. There is probably 12 to 15 generic --
6 manufacturers of the majority of the generic drugs that
7 supply to the country, and you will see their NDC and
8 AWP -- the two acronyms you have been hearing today --
9 they are all compromised -- most of them within 5 to 10%
10 of each other.

11 At the State level, Arizona has addressed
12 that by saying you must go manufacturer's original AWP,
13 number one. Number two, you specified an amount for both
14 generic and brand. Let me state that 85% of generic
15 original AWP state reimbursement rate in Arizona is one of
16 the lowest in the country. You guys are being
17 prospective. You have been reflective in how you are
18 adopting rules and regulations in the ICA, and you are on
19 the front side of the prospective curve.

20 Another of the three opponent points, if
21 you would, in the white paper study was that physician
22 dispensing prohibits public health surveillance. Maybe in
23 2011 for a large portion. Not today. The majority of
24 physicians use 1 or 2 pharmacy platforms that are as
25 advanced as every healthcare pharmacy platform in the

1 country. In fact, the pharmacy platform the majority of
2 the prescribers in Arizona use is a leader in prescription
3 monitoring programs, and I will be introducing to you guys
4 -- at least in the form of a letter to the CEO of the
5 company -- that they have been instrumental in not just
6 working with prescription drug monitoring programs. They
7 worked with many state enforcement agencies as a leader in
8 fighting opioid abuse and multiple prescriptions. I will
9 be happy to share that data via a letter and conversations
10 in the coming weeks.

11 On the fourth point, dispensing undermines
12 the mechanisms of drug safety, not just -- there is one
13 conversation about prescription drug monitoring multiple
14 physicians with opioid abuse. The other one is on the
15 payor side mentioned the safety.

16 We have the same software. We perform the
17 same as our company intends to -- what I'm telling you is
18 two of the largest prescribers in the state are clients of
19 mine, and we are able to use the same formularies as its
20 real-time. I would encourage in front of the panel now,
21 like, to have a conversation with some of the larger
22 payers in the states. We are happy to use the same
23 electronic methods. We are happy to use the same drug
24 utilization review mechanisms, and we can enforce those
25 within our electronic system. What this is really about

1 -- that addresses three of the four points.

2 The fourth point to me is what this is
3 about. If we make it about payers and providers and
4 special interest, the majority of the room here is usually
5 special interest on the extremes of both sides. That has
6 to do with enforceable networks or non-enforceable
7 networks. The majority of the price reduction comes
8 mostly from the ability to enforce networks, network
9 contracts and discounts. And I would provide that we
10 could submit the same level of scrutiny for the medical
11 services, for the utilization review, for everything else;
12 but we would like to get paid what the state fee schedule
13 is. And if there is a state fee schedule issued with the
14 pricing, by all means, let's reduce the state fee
15 schedule; and we are happy to have that conversation
16 across the board.

17 Gale made a great point, he did; but --
18 when I say "great point," he made a great point on 2 or 3
19 medications. If you find a subset of thousands of
20 medications and you find 2 or 3 of the outliers, I don't
21 think it -- doesn't do you guys a service to highlight
22 those medications. To that point, I say let's do away
23 with those medications. The ICA adopts the ODG
24 Guidelines, and there are ways to even further adopt more
25 guidelines that would exclude certain drugs from the

1 formulary. From my perspective, I care about the
2 longevity of the industry. I care about the rights of the
3 providers. At the same time, let's be reasonable. Let's
4 find the bad apples. Let's find the bad drugs.

5 As it relates to some of the other data
6 points you have heard today thus far, some of the
7 prescribers you have mentioned, you can't state -- you
8 can't quote a ratio of providers versus spend without
9 looking at a medication level. I'm not suggesting more
10 utilization. I'm not suggesting the cost isn't higher.
11 What I am suggesting is the doctors at the top of the list
12 represent thousands of patients in the state where the
13 average provider may have a subset of 1 or 2% more comp at
14 the tops, 70 to 90% more comp; and they have thousands of
15 patients. The devil is in the details, and I don't want
16 to parse through that. This isn't the right forum to
17 grant into those details. I'm open to having further
18 dialogue in the coming weeks. I hope to be part of that
19 process. I'm happy to share with you guys our expertise
20 and our knowledge and hopefully you find reasonable
21 solutions, but I think that's -- make sure I'm not missing
22 a point before I go sit down and my business partner
23 elbows me and says you forgot to say X.

24 I think I can close there. Thank you guys
25 for your time. Looking forward to continued dialogue on

1 this front and hope I can be of help to your decisions.

2 CHAIRMAN SCHULTZ: We look forward to your
3 comments. Thank you. Dr. Randall Prust.

4 DR. PRUST: Good afternoon. Thank you very much
5 for having me. Appreciate it. I have met earlier with
6 you, and I understand the issue to be more -- not a
7 physician dispensing issue -- but more really a custom
8 compound issue along with non-traditional drug formulas.
9 We use the example of Concentra. I think in their paper
10 they used the example of cyclobenzaprine.
11 Cyclobenzaprine, the traditional strengths were 5
12 milligrams and 10 milligrams; and somebody came out with a
13 7.5-milligram tablet; and one of the things -- which was I
14 think it was over two times the cost of the 5s or the 10s.
15 I have never dispensed 7.5 milligrams in my career. I
16 don't know why it is there.

17 I'm going to suggest a solution to that
18 issue. If you have non-traditional strength medications,
19 you can do, I think, two things. Let's take Tramadol,
20 that is only one strength. The traditional strength is
21 50 milligrams. I have heard there are 75-milligram pills.
22 That price drops down to 50 milligrams. There is only one
23 dose. That is the price. You can make 100-milligram
24 custom built. Just price it down with the 50-milligram
25 using the fee structures which are exactly the same for

1 pharmacies and physicians, .85 times AWP. If you have a
2 drug like cyclobenzaprine, 5 milligrams and 10 milligrams,
3 you have one in the middle; take the price of the 10 and
4 the 5; divide it by 2. That is the 7.5 or you can drop it
5 down to 5. I'm thinking that that would be a rather
6 simple solution.

7 The same could be said with custom compound
8 medications. The reason these are so highly priced, there
9 is an NBC for every medication in a custom compound. Now,
10 I don't use custom compounds, but I know how -- I know
11 what -- how they are priced. So each drug in there has an
12 AWP. You price it out at .85 times AWP. Now you have 6
13 or 7 drugs that you add up to get to these \$3,000 a month
14 type prescriptions which I think is ludicrous. So I think
15 the solution for that would be to -- there are a couple
16 solutions I will suggest.

17 Number one, allow one AWP in a custom
18 compound med if it meets the ODG criteria. There are
19 compound medications that do meet that criteria. Limit it
20 to one and cap it . Pick a price. I don't know what that
21 price would be. I don't use custom compounded
22 medications. I think that if you -- with some research,
23 it would be relatively easy, I think, to find what a
24 reasonable price might be the average wholesale price for
25 a compound; and that would be the cap. So that,

1 logically, I think someone who is billing for the compound
2 would probably pick the drug -- one drug with the highest
3 AWP which could still be 700 or 800 for just one
4 prescription, and I think again that would be a solution
5 to those two problems which I think my understanding
6 coming away from the meeting with you, those were the two
7 biggest concerns.

8 I wanted to say also that the ODG formulary
9 does take care of most of these problems. They have the
10 green drugs, and then the red drugs; and there are rules
11 that we use then to sometimes use red drugs, and those
12 rules are within the ODG, so I don't think we need to deal
13 with that. Our formularies are set. The rules are set.
14 The Commission has adopted it. Save those with repackaged
15 drugs, just what Todd said. We are going to have
16 repackaged drugs, not an issue. We have electronic
17 medical records. Safety is not an issue. I have all the
18 same mechanisms to check. I see every drug the patients
19 are on, when they received the medication, what the drug
20 interactions are. The point was well made, patients don't
21 remember their drugs nearly as well as I do in my
22 electronic medical record.

23 I think that -- I think that really
24 addresses the issues that I want to discuss, and I
25 hopefully have given you a couple solutions to these

1 problems; and again, I don't believe it is a physician
2 dispensing issue. You have already dealt with that issue
3 by making the pricing exactly the same for pharmacies and
4 doctors, and I think that they can respond to doctors
5 responsibly; dispense these medications because as they
6 showed, Senate Bill 1010 takes care of literally all the
7 opioid problems. I'm sure there could be some tweaking of
8 it. I think with the self-regulation that we have and you
9 have the Arizona Medical Board, the Arizona Board of
10 Pharmacy and the DEA that looks at doctors to help
11 regulate that field. I think that opioid area is also
12 covered very well. Thank you.

13 CHAIRMAN SCHULTZ: Thank you, Doctor. We
14 appreciate your input here and also in our stakeholder
15 meetings. Thank you. I know it is a trek up from Tucson.
16 We thank you.

17 Eileen Muro?

18 MS. MURO: Good afternoon, Chairman Schultz and
19 Members of the Commission. My name is Eileen Muro. I'm
20 an LPN, and I'm also the practice administrator for Dr.
21 Jeffrey Scott at Palo Brea Pain & Rehab. He couldn't be
22 here because of a telephonic hearing he had.

23 I would like to read to you the letter that
24 he submitted via the website yesterday in response to the
25 white paper. As a point of introduction, Dr. Scott is a

1 Board certified physician in physical medicine and
2 rehabilitation since 2002. He has dedicated his entire
3 practice to the treatment of injured workers since that
4 time and has been in practice in Arizona since 2008.
5 Based on this, he is comfortable in providing a voice in
6 the physician community with the regards to the "facts"
7 that were presented in this publication in an effort to
8 provide a brief yet cognizant response. He points out the
9 most salient points of this white paper that in his
10 opinion require feedback.

11 I will start by pointing out that many
12 statistical facts cited in WCRI statistical data between
13 2007 and 2011 in states where physician dispensing is
14 common such as Illinois, Georgia, Maryland and Louisiana
15 and notably not Arizona.

16 Furthermore, a bulk of this paper cites
17 information and statistics that are not applicable in
18 Arizona to either Arizona's manufactured based AWP
19 reimbursement, its enhanced restrictions on physician
20 dispensing of controlled substances and/or its imposition
21 of the ODG medication formulary. These actions, by
22 default, limit the relevancy of several sections of this
23 paper including repackaging, unmanaged prescriptions and
24 physician dispensing and opioid use.

25 In my opinion the public health impact of

1 physician dispensing contains hollow arguments in stating
2 that physician dispensing erodes the collective analysis
3 for drug-to-drug interactions and undermines the potential
4 benefits that come with digitization. Not only is that
5 argument antiquated with the advent of EMR, it is simply
6 inaccurate. Physicians are responsible for tracking
7 potential drug-to-drug interactions, not pharmacies, which
8 has been made easier with EMR.

9 Moreover, many patients choose separate
10 pharmacies for injury versus non-injury related
11 medications. Pharmacies, either accidentally or
12 intentionally, take the path of least resistance for
13 approval and payment of medications which most often is
14 the patient's private insurance regardless of whether the
15 treatment is for a work injury. I have received countless
16 "requires pre-authorization" notices from all the
17 well-known retail pharmacies who then either hold the
18 prescription or wait for someone to get it approved or
19 turn around and run it through the patient's private
20 insurance. Rarely have I received a notice from a PBM or
21 pharmacy regarding potential drug-to-drug interactions
22 even though they may be present. When I have, it
23 typically contains outdated information in which the
24 medication or medications in question have already been
25 discontinued or changed. I cannot recall a specific

1 example where this process directed either by a PBM or
2 pharmacy has been useful in my practice.

3 Our dispensing software also has a DUR
4 check. The additional scare tactic provided by this paper
5 is that physician dispensing undercuts the ability of drug
6 monitoring program to efficiently and effectively carry
7 out their function is simply inconsistent with Arizona law
8 as it relates to physician prescribing and dispensing.

9 Arizona already limits controlled substance
10 physician dispensing; requires CSPMP reporting of what
11 controlled substances are dispensed and mandates review of
12 the CSPMP prior to the controlled substance prescribing or
13 dispensing.

14 In summary, the analysis provided by the
15 white paper is skewed by the data compiled as most of
16 which appears to be generated by nationwide numbers
17 including states in which physician dispensing is common:
18 Illinois, Georgia, Maryland and Louisiana.

19 In my opinion many of the conclusions
20 rendered by this publication have limited to no
21 applicability in Arizona given the legislative changes
22 described above. In other words, the statistical axiom of
23 garbage in/garbage out applies. Unfortunately, the
24 Commission did not receive an analysis based solely on the
25 correct measures the State of Arizona already deploys.

1 It is also unfortunate the undertone of the
2 paper revolves around the cost containment without an
3 impartial discussion of the realities of cost shifting
4 from pharmacies to PBMs.

5 I would like to conclude by thanking the
6 Industrial Commission for providing an open forum to
7 discuss these issues. It continues to be in the best
8 interest of the entire Arizona workmen's compensation
9 system to identify any specific areas of concern,
10 particularly abuse, and address those concerns as they
11 arise.

12 As has been learned in other states,
13 painting broad legislative or administrative brush strokes
14 over specific problems drives willing, well-intentioned
15 and ethical workmen's comp providers out of the system.

16 I want to thank you for the opportunity to
17 speak on his behalf.

18 CHAIRMAN SCHULTZ: Thank you, and please thank
19 Dr. Scott.

20 Marc Osborn?

21 MR. OSBORN: Thank you, Members of the
22 Commission. For the record, my name is Marc Osborn, and
23 I'm here on behalf of PCIA. It is an interesting being in
24 the position -- presenting where half the audience you
25 look at the Commission or the audience, so please don't be

1 offended if I look at one side or the other. PCI is one
2 of the largest trade association representing workers'
3 comp insurers in the nation. So we have extensive
4 experience in all 50 states. We know the trends. We were
5 one of the organizations that approached the legislature
6 about addressing these issues. I think we wholeheartedly
7 support the comments of both ASIA and CopperPoint in terms
8 of the data that they showed; and when you are looking at
9 this and you talk to the local insurers and self-insurers,
10 they are the ones that see the data every day. And even
11 though there are variations between different states in
12 terms of ODG and the mix of pairs, I think you get a nice
13 trend from looking at the WCRI data in the industry -- I
14 think both on the Commission side and on the industry side
15 and all stakeholders aside -- WCRI is viewed as the gold
16 standard in terms of objective research.

17 What their finding clearly states is where
18 you have physician dispensing the health outcomes, in many
19 cases are worse than if you use traditional dispensing
20 methods. We believe that the physician dispensing is
21 basically an end-around PBMs and our ability to hold costs
22 down. You know, that pharmaceutical fee schedule is
23 designed to be the ceiling of costs; and I think the state
24 wants to encourage insurers, self-insurers to find the
25 most cost-effective options, especially when they are

1 beneficial to the patient; and I think by restricting
2 physician dispensing, you can achieve that.

3 We agree that physician dispensing isn't
4 always convenient for the patient. Going back to the
5 doctor's office time and time again may or may not be
6 convenient; whereas the number of retail pharmacies is far
7 more available. We do agree that there are some reduced
8 patient protections, and one of the things we want to look
9 at is enhancing as part of the fee schedule the
10 requirements of the providers to check databases. I think
11 that is a different discussion, and the same thing with
12 the ODG Guidelines. This is a discussion about physician
13 dispensing cost structures, fee schedules. We are happy
14 to have those dialogues as we fully implement ODG. It is
15 probably not appropriate for this.

16 If one of these physician dispensers
17 provided medical benefits, the payer community right here
18 supporting it, encouraging it, we don't see that. In
19 terms of our recommendations, we believe that you should
20 limit physician dispensing to no more than 7 days. And
21 that if you are going to dispense, the dispensing activity
22 should happen no later than 7 days after the injury. We
23 are open to discussing the kind of approach of maybe the
24 limit to that, but those are kind of our key limitations;
25 and I will be happy to answer any questions.

1 CHAIRMAN SCHULTZ: We are holding questions until
2 the end. Thank you for your comments.

3 Deb Baker?

4 MS. BAKER: Hello, Mr. Chairman, Commissioners,
5 Director and Counsels, thank you for giving me the
6 opportunity to speak. So many others have stole my
7 thunder.

8 CHAIRMAN SCHULTZ: Please introduce yourself.

9 MS. BAKER: I'm Debbie Baker. I'm the work comp
10 director for the Valley Schools Workers' Compensation
11 Group.

12 I completely agree with CopperPoint,
13 CorVel, ASIA, PCI and PCG. I think they have all done a
14 fabulous job addressing the very salient points. One
15 thing I would like to say is, yes, we have DEA; and we
16 have regulations and all this for opioids; and I could
17 stand here and name doctors that today are prescribing
18 opioids when they are getting drug tests back with
19 inconsistent results showing that the injured worker is
20 not taking opioids. They are taking methamphetamine or
21 other illicit drugs, yet the doctors continue to prescribe
22 opioids every 30 days.

23 So, yes, we have some things in place; and
24 I think that's wonderful, but I think we are taking baby
25 steps. And while we are taking those baby steps, addicts

1 are being created; and it's up to us as claims
2 professionals to step in and use the tools of our trade to
3 prevent the addiction. So speaking on behalf of Valley
4 Schools only, I'm totally against physicians dispensing
5 compounds and narcotics of any kind. I do agree. There
6 should be a formulary for physician dispensing if that's
7 going to be allowed; and I also feel that, yes, there
8 should be a time limit, maximum 7 days.

9 It has been said before, there are
10 pharmacies everywhere. PBMs do a wonderful job. There is
11 not a delay in medications getting approved. It is all
12 done electronically. They get approved. The injured
13 worker gets their medications, and they leave and they can
14 go to any pharmacy they choose. That's all I have to say.
15 Thank you for listening.

16 CHAIRMAN SCHULTZ: Thank you. Is there anyone
17 else who wishes to speak at this time? Trevor, how do we
18 connect to the folks on the phone? Does anyone on the
19 phone have -- wish to make any statements?

20 (Silence.)

21 CHAIRMAN SCHULTZ: Thank you. Now, we will move
22 to -- did I hear a response?

23 ELLEN (via phone): Mr. Chairman, this is Ellen
24 (inaudible) representing the American Insurance
25 Association, and I'm so sorry I cannot be there today.

1 I'm on the East Coast, and I let Jackie Kurth know that I
2 will be submitting comments by September; and we
3 appreciate the opportunity to weigh in that way. So thank
4 you very much.

5 CHAIRMAN SCHULTZ: Thank you, Ellen. We want to
6 create an opportunity for all participants to ask
7 questions. If you have questions concerning any of the
8 materials, any of the speakers, please come forward to the
9 podium and introduce yourself and state who you are
10 representing and proceed with the questions. Crickets.
11 I'm hearing crickets, and that's just fine.

12 I want to thank you all for coming today.
13 I know you have to take time out of your schedules to do
14 this, but the Commission very, very, very much appreciates
15 input from stakeholders as we go through our deliberations
16 and decide whether we are going to adopt any new rules,
17 regulations or parts to the pharmaceutical fee schedule.

18 So this will conclude the public hearing
19 concerning medications dispensed in settings that are not
20 accessible to the general public. We appreciate your
21 attendance and participation. As a reminder, although the
22 oral proceeding has concluded, written comments will be
23 accepted through the close of business on September 13th,
24 2018. Written comments may be submitted to Jackie Kurth,
25 Manager of the Medical Resource Office; and her contact

1 information is available on the Commission's web page,
2 AZCIA.gov. Thank you. We will adjourn temporarily and
3 move upstairs to conduct the rest of our Commission
4 meeting. Anyone who wishes to attend the rest of the
5 meeting can join us upstairs. Thank you all for coming.

6 (Proceedings concluded at 2:30 p.m.)

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1 STATE OF ARIZONA)
2)
3 COUNTY OF MARICOPA)

4 C E R T I F I C A T E

5 I, **MARLA F. KNOX**, Registered Professional
6 Reporter and Certified Reporter, Certificate No. 50870, in
7 and for the State of Arizona, do hereby certify that the
8 foregoing pages constitute a full, true and accurate
9 transcript of all proceedings had in the foregoing matter,
10 all done to the best of my skill and ability.

11 I FURTHER CERTIFY that I am not related to
12 nor employed by any of the parties hereto, and have no
13 interest in the outcome.

14 Dated in Phoenix, Arizona, this 18th day of
15 September, 2018.

16 /s/

17 **MARLA F. KNOX, CR, RPR, CRR**
18 **Certified Reporter No. 50870**

19 I certify that Perfecta Reporting has
20 complied with the requirements set forth in ACJA 7-201
21 Dated in Phoenix, Arizona this 18th day of September,
22 2018.

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